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Is Government Health Insurance Cheap?

The false comparison between the costs of public and private medical plans.

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Congress is currently away on a two-week recess, but weighty work is occurring in its absence. Staff negotiators are trying to come to agreement on a budget framework for 2010 and beyond. Although this is happening behind closed doors, it appears likely that the budget deal will eventually include a government-run health-insurance option, or "public plan," to compete with private health insurance under the comprehensive health-care reform called for by President Barack Obama.

Some lawmakers support or oppose a government-run health-insurance option for purely ideological reasons. Others are open to it because they are pragmatic and -- laudably -- want to be persuaded by data and facts. These moderates have been much influenced by the supposed fact that a public plan such as Medicare is more efficient than commercial insurance. Advocates of the public option routinely ask, "Aren't Medicare's administrative costs a fraction of those of private insurers?"

But the comparison between public and private plans is a false comparison. Private insurance and public benefits are not the same business. For all its warts, private insurance tries to manage care. Medicare is mostly about paying the bills presented to it.

Many who favor a public plan as part of comprehensive health-care reform dismiss the administrative "overhead" of private plans as having little or no value. Ways and Means Health Subcommittee Chairman Pete Stark (D., Calif.), for example, insists that "most private plans are poorly managed." Contrasting them with the supposedly sleek and efficient Medicare program, he labels commercial insurance "the General Motors of medical care."

In fact, the administrative expenses of private insurance plans represent money well spent for their members. Here are four reasons:

First, private insurers must build provider networks. These networks can include high-value providers and exclude low-quality providers. Except for certain circumstances, including criminal acts, Medicare is forbidden from excluding poor quality providers. It lets in everyone who signs up. So one question to ask is, will the public plan have Medicare's indifference to quality -- or invest in the cost of a network?

Second, private insurers must negotiate rates. Medicare just fixes prices using a statutory and regulatory scheme. And anyone who imagines a public plan would be less costly than private plans must keep the following issue front and center: In the many procedure categories where Medicare's statutory price does not cover full provider costs, shortfalls are shifted to private payers who end up subsidizing the public program. So, will a public plan negotiate rates or simply use fiat as a means of gaining subsidies from private insurance?

Third, private insurers must combat fraud -- or go out of business. Indeed, these payers have every incentive to invest in antifraud personnel and strategies down to the point where return and investment are equal. But anyone who thinks that a public plan could serve as a "yardstick" for the private sector needs to consider Medicare's dismal record with regard to fraud, waste and other abuse.

In fact, the total amount of Medicare fraud is unknown. The government does not measure or estimate fraud in its programs; instead, it measures payments made "in error." According to Medicare's own most recent data, payments made in error amount to over $10 billion annually. (Medicaid's payment errors in 2007 equaled a whopping $32.7 billion, according to a report by the Department of Health and Human Services.) Others have claimed Medicare's payments made in error are much higher. Even with the inclusion of the budget of the inspector general for the Department of Health and Human Services, Medicare spends less than one-fifth of 1% on antifraud measures -- a small fraction of what private plans invest in their efforts to build a network of honest providers.

Worse, in four of the past five years Congress has turned back Medicare's pleas for $579 million of additional antifraud funding, on the grounds that these dollars subtract from the budget funds for curing cancer and anti-obesity campaigns. Based on experience, Congress will always underinvest in fraud. Yet according to a House of Representatives Budget Committee hearing in July 2007, return on investment for certain Medicare antifraud measures were estimated to be in excess of 13-1. Will a public plan also hemorrhage from fraud because of chronic Congressional underinvestment?

Fourth, private insurers must incur the administrative cost of marketing. Medicare, of course, does not need to market. A public plan competing with other alternatives would have to market itself to the public, and this means tax dollars used to advertise against private plans. Or the public plan could "compete" by using heavily subsidized marketing channels not available to private insurers, such as Social Security mailings, welfare offices, unemployment check stuffers, and the constellation of government-funded "advocacy organizations."

None of these considerations should be interpreted as a defense of the status quo, or a denial of the fact that major health reform is needed. It is, and now.

There are indeed many places where commercial health insurance is inefficient -- for example, by trying to exclude the sick rather than compete for the business of managing their ailments more effectively. Moreover, the facilitation of a national insurance exchange could lower information and search costs for our increasingly mobile workforce.

But the impulse to "just pass something" -- a refrain heard often in the halls of Congress this spring -- is not good enough. There are more governmental paths to making things worse rather than better. As the case of Medicare's anemic anti-fraud efforts painfully illustrates, less management and lower administrative costs do not necessarily mean the program is really less costly. Fraud losses are just categorized as additional spending rather than as administrative expense.

Ultimately, the desire of many advocates of a government-run health plan to exaggerate Medicare's efficiency derives from the fact that the program does not make a profit. These folks are motivated by the naïve assumption that most of the health sector's ills could be cured if profit-seekers were excluded.

As the Congress continues the health-care debate, today behind closed doors, and soon in the open, there should be an honest discussion of administrative costs and their value. Those who believe that health care should have no profit should be open with their views and not hide behind the false economy of Medicare.

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